MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

OCC68 21

Reg. Dist. No.

P

1. PLACE OF DEATH:
County: Anne Arundle
City or town: Riveria Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Riveria Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John L. Armhein

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JULY 4 1929

8. AGE: Years	Months	Days	If less than one day
17	0	3	hrs. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)
10. Usual occupation: SCHOOL BOY
11. Industry or business

FATHER
12. Name: JOHN B. ARMHEIN
13. Birthplace: BALTO. MD.

MOTHER
14. Maiden name: RENA ROSSI
15. Birthplace: NORTH CAROLINA

16. Informant: JOHN B. ARMHEIN (FATHER)
Address: 1326 S? HIGHLAND AVE.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: JULY 11/46 (month) (day) (year)
Cemetery or crematory: SACRED HEART
Location: GERMAN HILL ROAD
18. Funeral director: Leilly & Geiler inc.
Address: 403 S. WOLFE ST

19. 7-9 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1946, at 3 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
accidental drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 7/7/46
Where did injury occur? Mt. Pleasant Beach (City or town) A. A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Stoney Creek.
Means of injury Injured at work?

23. SIGNATURE: Gustave F. Pancher M.D.
M. D. or other
Address: Glen Burnie Md. Date signed 7/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 06669 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ———

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1709 Pierce Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME: ANDERSON - IDA

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	widow

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1876 ?

8. AGE: Years	Months	Days	If less than one day
70 ?	unknown		——— hrs. ——— min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ———

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 1, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Baltimore City

18. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Schroeder St., Balto., Md.

19. July 31 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1946, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to July 28 1946 and that I last saw her alive on July 28 1946

Immediate cause of death: Chronic Myocarditis - General Arteriosclerosis — DURATION: Known to us since 7/1/46

Due to: ———

Due to: ———

Other conditions: Senile Psychosis — Known to us since 7/1/46
(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.: ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of: ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ———

Means of injury: ——— Injured at work? ———

23. SIGNATURE: Hart V. Armstead M. D. or other

Address: Crownsville, Maryland Date signed: 7/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

06670 Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:
128 Calvert St Annapolis Md.

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 Calvert St.
(If rural, give LOCATION)

2.(a) If veteran, name war: **********

3. (a) FULL NAME: Blanch R. Baden

3. (b) Social Security Number: 220-22-5598

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Divorced

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: ******* years

7. Birth date of deceased (mo., day, yr.): January 1, 1909

8. AGE: Years	Months	Days	If less than one day
37	6		...hrs. ...min.

9. Birthplace: Sudley A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Domestic Work.

11. Industry or business: None

FATHER
12. Name: George Barnett
13. Birthplace: Sudley Md.

MOTHER
14. Maiden name: Rebecca Gray
15. Birthplace: Sudley A. A. Co. Md.

16. Informant: Mrs Bessie Griffin
Address: 1409 Madison Ave. Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/ 14/ 46 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Chas. E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. July 13 1946 (Date rec'd by registrar)

Registrar: [signature]

MEDICAL CERTIFICATION:

20. DATE OF DEATH: July 11th 1946, at 3:10 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 45 to July 11th 1946 and that I last saw h alive on July 11th 1946

Immediate cause of death	DURATION
Heart Failure	
Due to: Acute Myocarditis	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other

Address: Annapolis, Md. Date signed 7/18/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B

Reg. Dist. No. 0664 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A.A. Co.
City or town: Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mon.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A. Co.
City or town: Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Magothy Beach Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Gardiner Bean

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	S.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 6-1890

8. AGE: Years 55 Months 9 Days 8 If less than one day: hrs. min.

9. Birthplace: St Mary's Co. Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Robert M Bean
13. Birthplace: Md.

MOTHER
14. Maiden name: Julia Gardiner
15. Birthplace: Md.

16. Informant: Mrs Jennie Huffington
Address: 3200 Hamilton Blvd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/46 (month) (day) (year)
Cemetery or crematory: Wood lawn
Location: Balto Co. Md

16. Funeral director: Wm Cook Inc
Address: 1217 St Paul Street

19. 7-16 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1946 at 9 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1930 to July 14 1946 and that I last saw h alive on July 12 1946

Immediate cause of death	DURATION
Cachexia	3 mo.
Due to: Pulmonary Tuberculosis.	10 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gberth. Mortimer Jr Med. M. D. or other
Address: 2706 St Paul St Date signed: 7/15/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

06672

P

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: A. A. Co
City or town: ~~Glen Burnie~~ Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A. Co
City or town: ~~Glen Burnie~~ Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 211. S 4th St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Pierre J Berger
3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): June 30th 1876
8. AGE: Years 70 Months 0 Days 12 If less than one day ... hrs. ... min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: ~~[illegible]~~
FATHER 12. Name: Andrew Berger
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Mary A. Raymond
15. Birthplace: York P.A.
16. Informant: Mercedes Sanders
Address: 211. S 4th St
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16-46 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location
18. Funeral director: Charles P Towell
Address: 2427 Edmondson Ave
19. July 18 1946 (Date rec'd by registrar) A W Jedonik [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12th 1946, at 12:50 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/8/46 19..., to 7/12/46 19...
and that I last saw him alive on 7/11/46 19...

Immediate cause of death	DURATION
Coronary Thrombosis	—
Due to	
Due to: Chronic Endocarditis, Arterio Sclerosis	Several
Other conditions: Chronic Interst. Nephritis	4 Years

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: John J Alexander M. D. or other
Address: Glen Burnie Md Date signed: 7/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55c)

06673

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Margate, P.O. Brooklyn 25
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: A. A.
City or town: Margate, P.O. Brooklyn, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs Jessie Mae Clayton

3. (b) Social Security Number:

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband ~~or wife~~: Chapman Clayton
6.(c) If alive, give age: 31 years
7. Birth date of deceased (mo., day, yr.): January 10 - 1915

8. AGE: Years: 31 Months: 7 Days: 5 If less than one day ....hrs. ....min.

9. Birthplace: St. Michaels, Talbot County, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William E. Tarbutton
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Annie C. Sadler
15. Birthplace: Maryland.

16. Informant: Mr. C. Clayton, Husband,
Address: Margate, Md.

17. B. (Burial, cremation, or removal. Which?) Date thereof: 7-18-46 (month) (day) (year)
Cemetery or crematory: Glen Haven.
Location: Glenburnie Md
18. Funeral director: J. L. McNeill
Address: 130 S. Fort Ave

19. 7-17 46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1946, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1946, to July 15 1946 and that I last saw her alive on 7/14/46 19..

Immediate cause of death: Melanoma of — DURATION: 1945
Due to: scapular with metastasis
Due to: pleura & axillary. —
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: Melanoma
University of Md. Hosp. Date of op. Aug-1945.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury Injured at work?

23. SIGNATURE: Gustave H. Fischer M.D. M. D. or other
Address: Glen Burnie, Md. Date signed: 7/15/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (144a)

CERTIFICATE OF DEATH

06674

Reg. Dist. No. 20

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County A A.

City or town Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A A

City or town Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Georgetta Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Raymond L Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 12 1895

8. AGE: Years 51 | Months 11 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace A. A. Co Md.

(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER 12. Name John W. Symes

13. Birthplace Pri Geo Co Md.

MOTHER 14. Maiden name Annie V Hardy

15. Birthplace A A Co Md.

16. Informant Raymond L Davis

Address Davidsonville A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1946 (month) (day) (year)

Cemetery or crematory Cedar Baptist Cemt

Location Annapolis Md.

18. Funeral director John W. Taylor Son

Address Annapolis Md.

19. July 15 (16) 1946 Carrie J. Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1946 at 11 A M

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Postmortem Examination 19..

~~[illegible]~~ July 13 1946

Immediate cause of death	DURATION
Due to Suicide by hanging	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 7/13/46

Where did injury occur? Davidsonville (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Hanged by neck Injured at work? No

23. SIGNATURE John M. Cooper M.D. Deputy Medical Examiner

M. D. or other

Address Annapolis Md. Date signed 7/15/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

06675

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Chesapeake Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland
County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2535 Arquith St
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME Ralph Diaz

3.(b) Social Security Number

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 1927

8. AGE: Years: 19 | Months: | Days: | If less than one day ... hrs. ... min.

9. Birthplace: New York City, N.Y. (Town, county, and state)
10. Usual occupation: Discharged - U.S. Navy 2 weeks ago
11. Industry or business: U.S.N.

FATHER
12. Name: Ralph Diaz
13. Birthplace: Puerto Rico

MOTHER
14. Maiden name: Catherine Morzenacki
15. Birthplace: Penna

16. Informant: Dr. Andres E. Celas
Address: Baltimore City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-16-46 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Balto Md
18. Funeral director: Guy A. Tayler
Address: Catonsville Md

19. 7/17 1945 M. S. DeAlba, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1946 at about 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination ~~19 ... and that I last saw h... alive on~~ July 13 1946

Immediate cause of death: | DURATION
Due to: Drowning
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident
Date of
Where did injury occur? Chesapeake Bay (City or town), A.A. (County), Md. (State)
Injured at home, farm, industry, public place (where?) Chesapeake Bay
Means of injury: Drowning
Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner, M.D. or other
Address: Annapolis Md
Date signed: 7/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-C)

CERTIFICATE OF DEATH

00676

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundle
City or town: Dorsey (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred: Forest Ave Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)
State: Md County: Baltimore City
City or town: Ellicott City (If outside city or town limits, write RURAL and give nearest town)
Street No.: Elmwood Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Clarence Dietz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife: 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1928

8. AGE: Years 18 | Months 6 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace: Ellicott City Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business: worked for United St. Ry

FATHER
12. Name: Chas. E. Dietz
13. Birthplace: U.S.A. - Md.

MOTHER
14. Maiden name: Florence M. Dietz
15. Birthplace: U.S.A. - Md.

16. Informant: Mrs. M. Jilek
Address: Forest Ave Hanover, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-25-46 (month) (day) (year)
Cemetery or crematory: Good Shepherd
Location: Ellicott City Md.

18. Funeral director: J. C. Dynnbathom
Address: Ellicott City Md

19. July 26 1946 (Date rec'd by registrar) Clara Kasluh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1946 at 3:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-30 1945 to 7-22 1946
and that I last saw h.. alive on July 17 1946

Immediate cause of death	DURATION
Metastases to Lung	1 year
Due to: Osteogenic Sarcoma	
Due to: of right clavicle	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles E Krachenfels M. D. or other
Address: 715 N Charles Date signed 7/22/46

CASE HISTORY

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06677

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 12 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Albert ELDER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 13, 1881

8. AGE: Years	Months	Days	If less than one day
64	9	27	hrs. min.

9. Birthplace: Rockville, Maryland
(Town, county, and state)

10. Usual occupation: Paper hanger

11. Industry or business: ---

FATHER
12. Name: William M. Elder
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lizay Jane Lilly
15. Birthplace: Maryland

16. Informant: Mrs Webster King
Address: 1 Hill St, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13 1946 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: BL Hopping & Son

Address: 170-172 West St. Annapolis, Md

19. July 13 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10, 1946 19 at 5P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10th 10 A M 19 46 to July 10. 5P 19 46 and that I last saw h[illegible] alive on July 10 19 46

Immediate cause of death	DURATION
Coronary Thrombosis	July 10
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Geo C Bond M. D. or other

Address: Annapolis Md Date signed: 7-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-a)

CERTIFICATE OF DEATH

06679

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Hrs

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 West St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: George Henry ELLIOTT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lavinia F. Elliott

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 12, 1878

8. AGE: Years	Months	Days	If less than one day
69	11	29	...hrs. ...min.

9. Birthplace: Calvert Co, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Algerman Elliott
13. Birthplace: St. Mary's Co., Md.

MOTHER
14. Maiden name: Elizabeth Dunn
15. Birthplace: St. Mary's Co. Md.

16. Informant: Mrs Lavinia F. Elliott
Address: 321 West St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14 46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: B.L. Horring & Son

Address: 170-172 West St. Annapolis, Md

19. July 13 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1946, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/11 1946, to 7/11 1946 and that I last saw h-- alive on 7/11 1946

Immediate cause of death	DURATION
intestinal obstruction	5 days
Due to strangulated or wd complete w/ hernia	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. Bernucker MD
M. D. or other

Address: Annapolis Md Date signed: 7/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

06680

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few seconds.

Hospital, institution, or street address where death occurred: Was dead upon arrival at ste

How long in hospital or institution? Emergency Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 78 - F Randall St.

(If rural), give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry Evans.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored.	Separated.

6.(b) Name of husband or wife: Bertha Evans

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1900

8. AGE: Years	Months	Days	If less than one day
45			..... hrs. ..... min.

9. Birthplace: Annapolis Md. A.A. Co. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Louis Evans

13. Birthplace: Md.

MOTHER — 14. Maiden name: Sophia Johnson

15. Birthplace: Md. A.A. Co.

16. Informant: Frank E. Evans

Address: Clay St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 5, 1946 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis Md.

19. July 2 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1st 1946, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	Sudden.
Due to Penetrated right lung.	
Due to .32 - Caliber Bullet.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 7/1/46

Where did injury occur? Annapolis (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Street

Means of injury ..... Injured at work?

23. SIGNATURE: Gustave A. Bachenheimer M.D. (Attending medical examiner) M. D. or other

Address: Glen Burnie, Md. Date signed: 7/1/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d.

CERTIFICATE OF DEATH

06678

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Church Home & Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Govans Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Carroll Hall
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John VanLear Findley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife: Divorced

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 1880

8. AGE: Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: none Retired

11. Industry or business

FATHER 12. Name: John VanLear Findley

13. Birthplace: Balto. Md.

MOTHER 14. Maiden name: Mary Keesey

15. Birthplace: Balto Md.

16. Informant: John VanLear Findley III

Address: 307 Alpine Rd. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 13 July 46 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Baltimore Md

18. Funeral director: Wm. J. Tichnor & Sons

Address: Baltimore Md

19. July 13 1946 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 July 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1946, to July 13 1946, and that I last saw h... alive on July 13 1946

Immediate cause of death	DURATION
Cerebral thrombosis	
Due to Generalized arteriosclerosis;	two months
Due to Arteriosclerotic heart disease;	
Duration: Not stated.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Donald H. Hooker M. D. or other

Address: 53 Cornell Date signed July 14 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6681 21

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater (Woodland Beach)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 412 Freeman St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Jane Gallagher
3.(b) Social Security Number: none

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: John Gallagher
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 26, 1857
8. AGE: Years: 88 Months: 7 Days: 24 If less than one day: hrs. min.
9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Samuel Haney
13. Birthplace: ~~Scotland~~ Ireland
MOTHER 14. Maiden name: Jane Robertson
15. Birthplace: Scotland
16. Informant: Mrs. Agnes McCarthy
Address: 412 Freeman St., Baltimore, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof July 23, 1946 (month) (day) (year)
Cemetery or crematory: Holy Cross - A.A. County
Location: A.A. County - Md.
18. Funeral director: West Cook Inc.
Address: 1217 St. Paul St. Baltimore Md.
19. 7/22/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1946, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~and that I last attended deceased on~~ Post mortem Examination to July 20 1946
Immediate cause of death: Acute dilatation of Heart — DURATION
Due to: Senility —
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: John M. Cluff M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 7/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

C6682

Reg. Diat. No. 21

FILE No. 1 O G AUG 13 1946

1. PLACE OF DEATH

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Grover L. Lucenot

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida B. Lucenot

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 20th 1885

8. AGE:

Years	Months	Days	If less than one day
60 -61-	11		..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Chef

11. Industry or business

FATHER — 12. Name: Frances Lucenot

FATHER — 13. Birthplace: France

MOTHER — 14. Maiden name: Marie M. Bush

MOTHER — 15. Birthplace: Paris France

16. Informant: Edward Lucenot

Address: Elk Club Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23rd 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor Jr. Son

Address: Annapolis Md.

19. July 23 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1946 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946 to July 20 1946

and that I last saw him alive on July 19 1946

Immediate cause of death: Carcinoma Stomach — DURATION: about 2 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C Rocel M. D. or other

Address: Annapolis Md Date signed: 7-22-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

06683

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Wash. D.C. County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2521 12th St. Wash. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME William Haddox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1946

8. AGE: Years | Months | Days | If less than one day: 2 hrs. 45 min.

9. Birthplace: ANNAPOLIS, MD.
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business:

FATHER
12. Name: George C. Haddox
13. Birthplace: Stanley, Va.

MOTHER
14. Maiden name: Mildred C. Lambert
15. Birthplace: Maryland

16. Informant: Elton K. Haddox
Address: 2521 12th St. Wash. D.C.

17. Burial (Burial, cremation, or removal, which?) Date thereof: 7-10-46 (month) (day) (year)
Cemetery or crematory: Mt. Hebron
Location: Winchester, Va.

18. Funeral director: John M. Layton & Son
Address: Annapolis, Md.

19. July 9 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1946, at 8 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1946, to July 8, 1946
and that I last saw him alive on July 8, 1946

	DURATION
Immediate cause of death: Prematurity	5 Months
Due to: Premature Labor	5 Mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Martin, M.D.
M. D. or other
Address: 185 Prince George St. Annapolis, Md. Date signed: 7-8-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06684

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. A.

City or town Jessups. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months.

Hospital, Institution, or street address where death occurred: Maryland House of Correction.

How long in hospital or institution? since 1/3/46

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County A. A.

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1715 Lorman St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Louis R. Harris

3. (b) Social Security Number

4. Sex M.

5. Color or race Black

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 2/28/25

8. AGE: Years 21 Months 4 Days 23 If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation "arabbing"

11. Industry or business

FATHER 12. Name Morris Harris

13. Birthplace ?

MOTHER 14. Maiden name ?

15. Birthplace ?

16. Informant House of Correction Records.

Address Jessups, Md.

17. Burial (Burial, cremation, or removal (Which?)) Date thereof July 25-46 (month) (day) (year)

Cemetery or crematory Cathedral

Location Baltimore City

18. Funeral director Geo. G. Nelson

Address 1303 Pressman St.

19. July 22 1946 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1946, at 9:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Acute congestive heart failure	sudden.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Gustave H. Paulsen M.D. M.D. or other

Acting Medical Examiner

Address Island Bussie, Md. Date signed 7/22/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

06685

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 18 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Severne Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Wineder W. Hunt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife: None

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 22, 1946

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
0	2	13		

9. Birthplace: Jones Sta. A. A. Co., Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Edward W. Hunt
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Edna Summersville
15. Birthplace: A. A. Co.

16. Informant: Hospital Record
Address: Annapolis.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1946 (month) (day) (year)
Cemetery or crematory: Carpenters Hill
Location: Jones A. A. Co.

18. Funeral director: C. B. Johnson
Address: Annapolis, Md.

19. July 6 1946 (Date rec'd by registrar) Registrar: O. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1946 at 3:28 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1946 to July 6 1946 and that I last saw h.i.m. alive on July 4, 1946

Immediate cause of death	DURATION
Cardio-respiratory failure	
Due to: Marasmus	
Due to: Malnutrition	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward P. Ritchings, M.D.
M. D. or other

Address: 194 Gloucester St. Date signed July 6, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

06686

CERTIFICATE OF DEATH

Reg. Dist. No. 21

I. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:
47 Northwest St.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 47 Northwest St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Catherine Estelle James

3.(b) Social Security Number: 214-12-3638

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: ****** years

7. Birth date of deceased (mo., day, yr.): May 27, 1896

8. AGE:	Years	Months	Days	If less than one day
	50	1		....hrs. ....min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: None

FATHER
12. Name: William Thomas James
13. Birthplace: Prince George County

MOTHER
14. Maiden name: Carrie Sedonia Bias
15. Birthplace: Annapolis Md. A. A. Co.

16. Informant: Mrs Carrie S. James

Address: 47 Northwest St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/7/46 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. July 5 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1946 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to July 1 1946 and that I last saw h.er alive on July 1 1946

Immediate cause of death	DURATION
Cardiac Failure	1 wk
Due to Mitral Insufficiency	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Theodore H. Johnson M.D. M. D. or other

Address: 40 Northwest Street Date signed 7/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-d

06687

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: Parole Md. A. A. Co.

How long in hospital or institution? xxxxxxxxxxxxxx

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Parole Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Parole (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Susie Johnson

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: WM. Henry Johnson

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): December 1873

8. AGE: Years: 70 Months: 7 Days: If less than one day: ... hrs. ... min.

9. Birthplace: Prince George Co. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Wm. Betters

13. Birthplace: Unknown

MOTHER

14. Maiden name: Sarah Brooks Betters

15. Birthplace: Prince George Co. Md.

16. Informant: Mrs Ethel Johnson

Address: Parole Md. A. A. Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/ 5/ 46 (month) (day) (year)

Cemetery or crematory: Fowlers Chapel Cemetery

Location: Best Gate Md. A. A. Co.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. July 5 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1946, at 7:45 Am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 44, to July 2 1946 and that I last saw her alive on July 2 1946

Immediate cause of death: Myocardial Failure

Due to: Chronic Myocarditis — DURATION: 5 Years

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other

Address: [illegible] Date signed: 7/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

06688

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 25 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 4 years, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town: Palmer's Post Office

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: JONES - DAWKINS (James)

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Margaret Jones, Palmers, St. Mary's Co., Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): December 16, 1901

8. AGE: Years	Months	Days	If less than one day
44	6	26	--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: -----

FATHER — 12. Name: James Darby Jones

13. Birthplace: unknown

MOTHER — 14. Maiden name: Anna Hopps

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/18/46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

16. Funeral director: Supt. Hospital

Address: Crownsville, Md.

19. July 18 1946 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 42, to July 12 19 46

and that I last saw him alive on July 12 19 46

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since 6/8/46
Due to: ------	
Due to: ------	
Other conditions: General Paresis	Known to us since 6/17/42

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.: ------

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: ------

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: ------ Injured at work? ------

23. SIGNATURE: Paul J. Schnabel M. D. or other

Address: Crownsville, Maryland Date signed: 7/12/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

06690

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 239 West St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Tillie KOTZIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Max Kotzin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 28, 1887

8. AGE:	Years	Months	Days	If less than one day
	59	3	17	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: ---

11. Industry or business: ---

FATHER
12. Name: Solonon Lawenthal
13. Birthplace: Russia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr. Herbert Kotzin

Address: 22 Steel St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 1946 (month) (day) (year)

Cemetery or crematory: Kneseth Israel Cemetery

Location: Best Gate, A.A. Co. Md

18. Funeral director: B.L. Horning & Son

Address: 170-172 West St. Annapolis, Md.

19. July 14 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1946 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1946, to July 14 1946 and that I last saw h[illegible] alive on July 14 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	July 3
Due to: Arteriosclerosis	unknown
Due to:	
Other conditions: Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: George C Boul M. D. or other

Address: Annapolis Md Date signed 7.14.46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

06691

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: RURAL MARGATE - NEAR Glen Burnie
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: R.F.D. 9 Leymar & Midland Roads Box 32
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 YRS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ANNE ARUNDEL
City or town: RURAL NEAR Glen Burnie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: RURAL — LEYMAR & MIDLAND Rds.
F.D. #9 (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: JOHN WILLIAM LAMBERT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED.

6 (b) Name of ~~husband~~ wife: EDNA I. LAMBERT. (Nee SPIKER)
6(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): JUNE 5, 1899

8. AGE:

Years	Months	Days	If less than one day
47	1	21	____ hrs. ____ min.

9. Birthplace: BALTIMORE, MARYLAND (Town, county, and state)
10. Usual occupation: GUARD & CHAUFFEUR.
11. Industry or business: SHIP YARD. (Bethelem)

FATHER
12. Name: WILLIAM JAS. LAMBERT.
13. Birthplace: BALTIMORE, MARYLAND

MOTHER
14. Maiden name: LAURA V. LOWERY
15. Birthplace: BALTIMORE, MARYLAND

16. Informant: MRS. EDNA I. LAMBERT. (Wife)
Address: MARGATE, A. A. Co. MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29/46 (month) (day) (year)
Cemetery or crematory: Anne Arundel Glen Haven Cem.
Location: Anne Arundel Co., Md.
18. Funeral director: A. Howard Evans
Address: 1400 S. Charles St. Balto. 30, Md.

19. 7/29 1946 (Date rec'd by registrar) A. W. Hedgepeth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1946, at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I did not attended deceased from Not SEEN 19__ to ALIVE 19__, and that I last saw him alive on 19__.

Immediate cause of death: CORONARY THROMBOSIS — DURATION:
Due to: UNKNOWN
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry F. Zangara M.D. M. D. or other
Address: Glen Burnie, Md. Date signed: July 26, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06692

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ years
Hospital, institution, or street address where death occurred:
District Training School
How long in hospital or institution? 2½ years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1355 H. Street N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Raymond Charles Love

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23 1934

8. AGE: Years	Months	Days	If less than one day
12	0	21	hrs. min.

9. Birthplace: D.C.
(Town, county, and state)
10. Usual occupation: Inmate
11. Industry or business

FATHER
12. Name: Jacob Love
13. Birthplace: Russia

MOTHER
14. Maiden name: Esther —
15. Birthplace: Russia

16. Informant: Record of District Training School
Address: Laurel, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 15-46 (month) (day) (year)

Cemetery or crematory:
Location: Washington DC

18. Funeral director: B Darmansky & Son
Address: 3501-14th St N.W.

19. July 15 1946 (Date rec'd by registrar) Clara Kaslich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1946, at 8.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1944, to July 14 1946 and that I last saw him alive on July 14 1946

Immediate cause of death	DURATION
Bronchopneumonia	24 hr
Due to	
Due to	
Other conditions: Vincents Infection, Mongolism	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Allan M. Drummond M.D. (M. D. or other)
Address: District Training School Date signed: 7-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

06693-21

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No.

Village or City Shadyside No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Gertrude Niemyer Mangels Gertrude Niemyer Mangels If U. S. Veteran, specify WAR

(a) Residence: No. Bloomsbury apts. St. Ward. Balt. Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard M. Mangels.

6. DATE OF BIRTH (month, day, and year) July 21, 1878

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	11	14 days	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. housewife.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balt. Md.

FATHER

13. NAME Henry W.m - Niemeyer.

14. BIRTHPLACE (city or town) (State or country) Germany.

MOTHER

15. MAIDEN NAME Wilhelmina - Meneberger.

16. BIRTHPLACE (city or town) (State or country) Germany.

17. INFORMANT (Address) Louise Neilsons Mangels

18. BURIAL, CREMATION, OR REMOVAL

Place Oak Lawn Date July 8, 1946

19. UNDERTAKER William Cook Inc.

(Address) 2427 St. Paul - Balt. Md.

20. FILED 7-8-46 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 5, 1946 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1946, to July 5, 1946

I last saw h- alive on July 1, 1946, death is said to have occurred on the data stated above, at 5a m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary occlusion	

Other Contributory Causes of importance:

hypertension	
arteriosclerosis -	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Emily H. Wilson M. D.

(Address) Galesville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

06694

Reg. Diat. No. 26

P

1. PLACE OF DEATH:
County A-A
City or town Crownsville (Md)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months 3 weeks 5 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 months 3 weeks 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) No home
State ..... County .....
City or town .....
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Pleasant Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	widower

6.(b) Name of husband or wife Ina Known
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Alfred Martin (John)
13. Birthplace Md
MOTHER 14. Maiden name Eliza Owens
15. Birthplace Md.
16. Informant Helen Owens
Address 577 Prestman St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/3/46 (month) (day) (year)
Cemetery ~~or crematory~~ Mt. Calvary
Location Cedar Hill Lodge
18. Funeral director Adkins & Garland
Address 918 Druid Hill Ave
19. 8-31 46 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1946 at 4:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-4- 1946 to 7-30- 1946 and that I last saw h.im alive on 7-30- 1946

Immediate cause of death	DURATION
Generalized arterio-sclerosis	Known to The hospital since admission (3-4-46)
Due to	
Due to	
Other conditions Senile Psychosis agitated and depressed type	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Alfred J. Gardner M. D. or other
Address ..... Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

66695 Q2

★ Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Anne Arundle
City or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A A Co.
City or town Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Montevideo Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Mathew [redacted] Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of ~~husband~~ or wife Lillian May [redacted] Miller
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Mar 13, 1898

8. AGE: Years	Months	Days	If less than one day
48	4	6	..... hrs. ..... min.

9. Birthplace Adoquee, N C (Town, county, and state)
10. Usual occupation Lumberman
11. Industry or business Sawmill
12. Name (FATHER) Charles M Miller
13. Birthplace (FATHER) Adoquee
14. Maiden name (MOTHER) Lula West
15. Birthplace (MOTHER) Adoquee, NC
16. Informant Mrs Lillian M Miller
Address Laurel Md
17. Burial, cremation, or removal. Which? Burial Date thereof July 23 1946 (month) (day) (year)
Cemetery or crematory Meadow Ridge Mem Pk
Location Laurel Md
18. Funeral director W H Donaldson
Address Laurel Md.
19. 7/24/46 19..... (Date rec'd by registrar) Clara Haskell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1946, at 1° A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1946, to July 20 1946 and that I last saw him alive on July 19 1946

Immediate cause of death	DURATION
Suffocation	
Due to Carcinoma right lung	8 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death shenld be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the followlg:
Accident, suicide, or homicide Date of
Where did lojury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John D Stephens M D
M. D. or other
Address Laurel Date signed 7/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

06696

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County
City or town: Washington.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3227 D st. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: W. Edwin Mitchell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife:
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Mar 27 1898

8. AGE: Years	Months	Days	If less than one day
48			... hrs. ... min.

9. Birthplace: Washington
(Town, county, and state)

10. Usual occupation: Veterans Administration

11. Industry or business: U.S. Government

FATHER
12. Name: F. Edwin Mitchell
13. Birthplace: Washington D C

MOTHER
14. Maiden name: Anna M. Wheatley
15. Birthplace: Wash. D.C.

16. Informant: Mrs Herbert L. Brown
Address: Riviera Beach, Pasadena P.O., Md

17. burial — Date thereof: July 25 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Arlington National Cem.
Location: Washington D.C.

18. Funeral director: James T. Ryan Inc
Address: 317 Penna ave S.E. Wash. D.C.

19. July 22 1946 — W R Dealba Dep. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1946 at about 7 P. M.

21. I CERTIFY that death occurred on the date above stated; Postmortem Examination July 22 1946

Immediate cause of death: Drowning

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident — Date of: 7/21/46
Where did injury occur? near Riviera Beach, A.A., Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Stony Creek
Means of injury: Drowning — Injured at work? no

23. SIGNATURE: John M. Claffy, M.D., Deputy medical Examiner
M. D. or other
Address: Annapolis, Md. — Date signed 7/22/46

COPY SENT TO Co. REGISTRAR No. DATE 7/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-6)

CERTIFICATE OF DEATH

8

06697 25
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 2 mo, 18 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr, 2 mo, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 520 North Stricker Street (If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: MYERS - MARY LEE LOGAN

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	Married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): August 26, 1926

8. AGE: Years	Months	Days	If less than one day
19	11	2	——— hrs. ——— min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ———

FATHER
12. Name: Frank Logan
13. Birthplace: Virginia

MOTHER
14. Maiden name: Justine Pinkney
15. Birthplace: Georgia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 2 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Anne Arundel County

18. Funeral director: Mrs. Katie R. Williams
Address: 322 N. Schroeder St., Balto., Md.

19. July 31 19 46 (Date rec'd by registrar) A. W. Hedges Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 46 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 45 to July 28 19 46 and that I last saw her alive on July 28 19 46

	DURATION
Immediate cause of death: Exhaustion	
Due to: Schizophrenia	Known to us since 5/10/45
Due to: ———	
Other conditions: Rheumatic Heart Disease (Include pregnancy within 3 months of death)	Known to us since 5/10/45

Major findings of operations: ———
Date of op.: ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of: ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Hart V. Schroeder M. D. or other
Address: Crownsville, Maryland Date signed: 7/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

06698 21
Reg. Dist. No.

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ANNE ARUNDEL
City or town FERNDALE
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 505 N. ANNAPOLIS BLVD
Stay in hospital or insf. (yrs., or mos., or days) NONE
Stay in this community (yrs., or mos., or days) 5 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ANNE ARUNDEL
City or town FERNDALE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 505 N. ANNAPOLIS BLVD
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ROSA ANNA NORRIS

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED.

6 (b) Name of husband ~~or wife~~ HARRY EDWARD NORRIS
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JANUARY 23, 1880

8. AGE:

Years	Months	Days	If less than one day
66	5	15	____ hrs. ____ min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual occupation HOUSE WIFE
11. Indusfry or business

FATHER
12. Name JOSEPH BERRYMAN
13. Birthplace GERMANY

MOTHER
14. Maiden name ELIZABETH (UNKNOWN)
15. Birthplace BALTIMORE, MARYLAND

16. Informant MRS. EVELYN ANDERSON
Address 505 N. ANNAPOLIS BLVD.

17. Burial Date thereof 7-11-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Baltimore, Md.
18. Funeral director Flynn & Flynn
Address 1426 Light St.

19. 7-9 19 46 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 28 1946, to JULY 8 1946, and that I last saw her alive on JULY 8 1946.

Immediate cause of death	DURATION
UREMIA.	
Due to CHRONIC ARTERIOSCLEROTIC KIDNEYS	
Due to GENERALIZED ARTERIOSCLEROSIS	
Other conditions CORONARY SCLEROSIS AND ANGINA PECTORIS	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Henry F. Bangua M.D.
M. D. or other
Address 401 W. ANNAPOLIS BLVD Date signed July 8, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

06699

CERTIFICATE OF DEATH

★ Reg. Diat. No. 22

1. PLACE OF DEATH:

County: A.A.

City or town: Laurel Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundle

City or town: Laurel Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Camp Meade R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Robert Bentley O'Neil

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Nellie O'Neil

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1880

8. AGE: Years	Months	Days	If less than one day
66	5	6	..... hrs. ..... min.

9. Birthplace: Pulaski, Va. (Town, county, and state)

10. Usual occupation: Lumberman

11. Industry or business: Sawmill

FATHER 12. Name: Jerry O'Neil

13. Birthplace: Pulaski Va.

MOTHER 14. Maiden name: Sarah Cooper

15. Birthplace: Tenn.

16. Informant: Mrs Nellie O'Neil

Address: Laurel Md R.F.D. (22)

17. Burial (Burial, cremation or removal, which) Date thereof July 22 1946 (Month) (Day) (Year)

Cemetery or crematory: Cecil Chapel Cemty

Location: Snowville Va.

18. Funeral director: Mc Keith Donaldson

Address: Laurel Md.

19. 7/26/46 19..... (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1946 at 10 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1946 to July 19 1946 and that I last saw h.. alive on July 9 1946

	DURATION
Immediate cause of death: Congestive Heart failure	3 months
Due to: Rheumatic Heart Disease	9 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John A. Hayden M.D. M. D. or other

Address: Laurel Maryland Date signed 7/20/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2a

06700 8

CERTIFICATE OF DEATH

Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 541 Oxford Street (If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: PARKER - ROY

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 48 | Months: unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: ------

FATHER 12. Name: Ermatt Parker

FATHER 13. Birthplace: unknown

MOTHER 14. Maiden name: Julie Atkinson

MOTHER 15. Birthplace: unknown

18. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 18, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Anne Arundel County, Maryland

18. Funeral director: Geo. G. Kelson

Address: 1303 Presstman St., Balto., Md.

19. 7/16/46 (Date rec'd by registrar) H. W. Helmick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1946, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6, 1946, to July 14, 1946 and that I last saw him alive on July 14, 1946

	DURATION
Immediate cause of death: Acute Meningitis	Known to us since 7/6/46
Due to: ------	
Due to: ------	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op. ------

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of ------

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury ------ Injured at work? ------

23. SIGNATURE: Albert L. Bosworth M. D. or other

Address: Crownsville, Maryland Date signed: 7/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

06701

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Neck Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Neck
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Parker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Samuel Parker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: Years: 80 Months: ? Days: ? If less than one day: ..... hrs. ..... min.

9. Birthplace: Calvert Co.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: John Kents
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Reed
15. Birthplace: Md.

16. Informant: Sarah Jenkins

Address: 6 Taylor St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 1946 (month) (day) (year)

Cemetery or crematory: Annapolis Neck

Location: Annapolis Neck, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis, Md.

19. July 29 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1946, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1946, to July 27 1946

and that I last saw h.. alive on July 26 1946

Immediate cause of death	DURATION
Chr. Nephritis & Edema	6 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. F. Kenwood, Md
M. D. or other

Address: 31 Smithgate Ave Date signed: 7/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

06702 1

CERTIFICATE OF DEATH

Reg. Diat. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Greenland Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No. 613 N Clinton

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Clarence E Parthree

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Catherine Parthree

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 5 1888

8. AGE: Years	Months	Days	If less than one day
57	7	29	....hrs. ....min.

8. Birthplace: Balto (Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business

FATHER — 12. Name: Joseph Parthree

13. Birthplace: Md

MOTHER — 14. Maiden name: Margt Gerrard

15. Birthplace: Md

16. Informant: Mrs Catherine Parthree

Address: 613 N Clinton

17. Burial, cremation, or removal. Which?: Burial Date thereof: July 29/46 (month) (day) (year)

Cemetery or crematory: Burial Oak Lawn

Location: Balto Co Md

18. Funeral director: Welsh Funeral Home

Address: 2008 Orleans St

19. 7/29/46 (Date rec'd by registrar) 19 46 A W Fiedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 19 46 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 46 to July 25 19 46

and that I last saw h.. alive on July 25 19 46

Immediate cause of death	DURATION
Carcinoma Lungs	3-4 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Pasadena Beach Md Date signed: 7/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06703

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:
17 Jefferson St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Jefferson St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rachel C. Phipps

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	M

6.(b) Name of husband or wife Julius Phipps

6.(c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1866

8. AGE: Years	Months	Days	If less than one day
79	9	5	...hrs. ...min.

9. Birthplace Maryland A.A. Co.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Louis Ford

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Sarah Penny

MOTHER 15. Birthplace Maryland

16. Informant Mr. Louis N. Phipps

Address Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7/46 (month) (day) (year)

Cemetery or crematory St. James

Location Lothian - md.

18. Funeral director Ben L. Hopping & Son

Address 170-172 West St. Annapolis, Md

19. July 6 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 46 at 7:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19 to July 5 19 46

and that I last saw h[illegible] alive on July 4 19 46

	DURATION
Immediate cause of death Acute dilatation of	
Due to the Heart	Unknown
Due to	
Other conditions Arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Luther L. Anderson M.D.
M. D. or other

Address Annapolis Md. Date signed 7/6/46

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

06704 8

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County A A Co.

City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:
210 Arundel Rd

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A A Co

City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)

Street No. 210 Arundel Rd
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Alice M. Pumphrey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife George W.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22, 1867

8. AGE: Years 78 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name John Hale
13. Birthplace Md

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mr George T Hopper
Address 210 Arundel Rd

17. Burial (Burial, cremation, or removal Which?) Date thereof 7/16/46 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18. Funeral director John T Kenny Inc

Address 716 Eight St Anne Arundel

19. 7-16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13th 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to July 1 1946
and that I last saw h[illegible] R. alive on July 6 1946

Immediate cause of death	DURATION
a Coronary occlusion	
Due to Hypertension and a	
Vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Paul Kristen MD
M. D. or other

Address 302 Talapsew Ave Date signed July 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

302 Patapsco Ave
(Dr Keister)

Evidence for change of age of deceased is shown on FILM No. I 06 JUL 31 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06705

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 193 Gloucester St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cecelia Clausen Robeck

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William Robeck
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 11 1878

8. AGE: Years	Months	Days	If less than one day
67 -68-	9	7	..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual occupation Home wife
11. Industry or business

FATHER
12. Name Rasmus Clausen
13. Birthplace Denmark

MOTHER
14. Maiden name Elizabeth Dunker
15. Birthplace Annapolis Md.

16. Informant Alma E. Robeck
Address 193 Gloucester St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1946 (month) (day) (year)
Cemetery or crematory St Mary's
Location Annapolis Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.

19. July 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1946, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1946 to July 18 1946 and that I last saw h... alive on July 18 1946

Immediate cause of death ... Myocardial Infarct with Myocardial Insufficiency — DURATION 1 week

Due to Carcinoma of Colon — 3 Months

Due to ... — Fatal

Other conditions Cholelithiasis

(Ioclode pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statisticaDy.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE George E. Boal M. D. or other
Address Annapolis Md. Date signed 7-19-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06728

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 20 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 6 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 65 Park Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: ROBINSON - ROSALIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: James Robinson, Cambridge, Maryland

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1915

8. AGE: Years	Months	Days	If less than one day
31	unknown		___ hrs. ___ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Netter ?
15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 19, 1946 (month) (day) (year)

Cemetery or crematory: Waugh Cemetery

Location: Cambridge, Maryland

18. Funeral director: H. M. St. Claire & Son

Address: Cambridge, Maryland

19. July 17 1946 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16 1946 at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 1945, to July 16 1946 and that I last saw her alive on July 16 1946

	DURATION
Immediate cause of death: General Paresis	Known to us since 12/26/45
Due to: ___	
Due to: ___	
Other conditions: ___	

(Include pregnancy within 3 months of death)

Major findings of operation: ___ Date of op.: ___

Autopsy results: ___

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ___ Date of: ___

Where did injury occur? ___ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ___

Means of injury: ___ Injured at work? ___

23. SIGNATURE: Albert V. Finkbeiner M. D. or other

Address: Crownsville, Maryland Date signed: 7/16/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

06707

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Cypress Cut - P.O. Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? New Comer.
Hospital, Institution, or street address where death occurred:
Cypress Cut.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Anne Arundel~~
City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2748 - Tivoly Ave -
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carlos M. Rodriguez

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife: --
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 2, 1918

8. AGE: Years	Months	Days	If less than one day
28	1	2	hrs. min.

9. Birthplace: Ponce, Puerto Rico (Town, county, and state)
10. Usual occupation: Interpreter
11. Industry or business: Butler Bros. Company
FATHER 12. Name: Roman Rodriguez
13. Birthplace: Ponce, Puerto Rico
MOTHER 14. Maiden name: Ben Saba
15. Birthplace: Ponce, Puerto Rico
16. Informant: Mr. James F. Rankins
Address: 1808 N. Calvert St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/8/46 (month) (day) (year)
Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 7/5 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 19 46, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__
and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
accidental drowning	Sudden
Due to	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 7/4/46
Where did injury occur? Cypress Cut, A.A. 2nd.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Cypress Cut
Means of injury: Drowning. Injured at work? No

23. SIGNATURE: Gustave A. Faubert M.D.
Acting medical examiner M. D. or other
Address: Glen Burnie Md. Date signed 7/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

06708

CERTIFICATE OF DEATH

Reg. Diat. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. Co.
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Lilly Sanders

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Married

6.(b) Name of husband or wife: Edward Sanders
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): July 29. 1906

8. AGE: Years: 39 Months: 11 Days: 8 If less than one day: hrs. min.

9. Birthplace: Galesville
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Benjamin Growzer
13. Birthplace: Galesville

MOTHER
14. Maiden name: Lovie Growzer
15. Birthplace: Galesville Md

16. Informant: Wm Growzer
Address: Galesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10. 1946 (month) (day) (year)
Cemetery or crematory: Galesville Cem
Location: Galesville Md
18. Funeral director: H. A. Saudenberg & Son
Address: Galesville Md.

19. 7/10 1946 (Date rec'd by registrar) H. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1946 at 11½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1946, to July 7 1946
and that I last saw h[illegible] alive on July 6 1946

Immediate cause of death: Carcinoma of Liver.

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson M. D. or other
Address: Lothian, Md. Date signed: 7/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

06709

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 4 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 7 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 213 North Arlington Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: -----

3. (a) FULL NAME: SAUNDERS - LOUIS

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Mary Saunders, 213 N. Arlington Ave., Balto. Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): May 4, 1904

8. AGE: Years	Months	Days	If less than one day
42	2	7	--- hrs. ----- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER 12. Name: Beverley Saunders

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Henriette Burden

MOTHER 15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: July 15, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Anne Arundel County

18. Funeral director: Isiah L. Brown & Son

Address: 108 W. Montgomery St., Balto., Md.

19. 7-16-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 19 46, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7 19 45, to July 11 19 46 and that I last saw him alive on July 11 19 46

Immediate cause of death	DURATION
Post Epilepsy is Epilepsy with	Known to us since 12/7/45
Due to: -----	
Due to: -----	
Other conditions: Post-traumatic Epilepsy with Psychosis (Include pregnancy within 3 months of death)	Known to us since 12/7/45

Major findings of operations: -----

Date of op.: -----

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of: -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: ----- Injured at work? -----

23. SIGNATURE: Herbert L. Armstrong M. D. or other

Address: Crownsville, Maryland Date signed: 7/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (HE)

06710

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Old Annapolis Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mary Catherine SCHULTZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband ~~or wife~~: Joseph Charles Schultz
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): Sept 1 - 1890

8. AGE: Years	Months	Days	If less than one day
50	10	20	..... hrs. ..... min.

9. Birthplace: Hartford County, Md.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business:
FATHER 12. Name: Charles H. Kisel
13. Birthplace: Maryland.
MOTHER 14. Maiden name: Mary Welicks
15. Birthplace: Maryland.
16. Informant: J. C. Schultz - husband.
Address: Pasadena, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. July 22 1946 (Date rec'd by registrar) W. K. Dealer Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1946, at 2.15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to July 20 1946 and that I last saw her alive on 7/20/46 1946

Immediate cause of death	DURATION
Bronchial Pneumonia	1 day.
Due to: Cancer of the stomach	2 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Faulenbush M.D.
M. D. or other
Address: Glen Burnie, Md. Date signed: 7/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

COPY SENT TO LOCAL REGISTRAR [redacted] DATE 7/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

06711

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Harwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, institution, or street address where death occurred:

Harwood, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Harwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Hildt SHEPHERD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sallie N.

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1872

8. AGE: Years	Months	Days	If less than one day
73	8	24	hrs. min.

9. Birthplace: Mt. Zion, A.A. Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ----

FATHER — 12. Name: Owens Shepherd

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Kate Hildt

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs Sallie N. Shepherd

Address: Harwood, A.A. Co. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 24, 46 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Lothian Maryland

18. Funeral director: Ben L. Horring & Son

Address: 170-172 West St. Annapolis, Md.

19. 7/24 19 46 W. P. Clayton Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22, 1946 19 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-22 19 46 to 7-22 19 46 and that I last saw him alive on 7-22 19 46

Immediate cause of death	DURATION
circulatory failure	
Due to carcinomas of lungs ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edith Roelke M.D. M. D., or other

Address: 42 State Circle Annapolis Date signed: 7-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ 06712 20

Reg. Dist. No. .....

1. PLACE OF DEATH: County: Anne Arundel; City or town: Grimork (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Bristol (If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Mary Josephine Shepherd

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 16, 1883

8. AGE: Years: 63 | Months: 9 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bristol Md (Town, county, and state)

10. Usual occupation: Home Keeper

11. Industry or business: .....

FATHER — 12. Name: John Shepherd

FATHER — 13. Birthplace: Bristol

MOTHER — 14. Maiden name: Mary Suey Smith

MOTHER — 15. Birthplace: Lafayette Ind

16. Informant: Ashly Shepherd

Address: Bristol. Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug 2 1946 (month) (day) (year)

Cemetery or crematory: Mt View Cem.

Location: Lothian, Md

18. Funeral director: F. A. Gardiner & Son

Address: Galesville Md

19. Aug 1 1946 (Date rec'd by registrar) H. L. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1946, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1944, to July 31 1946 and that I last saw h.. alive on June 15 1946

Immediate cause of death	DURATION
Myocarditis Chronic	2 Yrs.
Due to Polyarthritis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. C. Yost M.D. M. D. or other

Address: Lothian Md Date signed: 8-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

06713

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Sudley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1554 Riggs Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Christina Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	widow

6.(b) Name of husband or wife: William
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12/11/1886

8. AGE: Years: 59 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: md
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: James Handy
13. Birthplace: md

MOTHER — 14. Maiden name:
15. Birthplace

18. Informant: James Smith
Address: 1126 N. Calhoun St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/26/46 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Md

18. Funeral director: Geo. L. Kelson
Address: 1303 Pressman St

19. 7-24-46 (Date rec'd by registrar) Arundel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1946, at 6 50 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination 19.. ~~and that I last saw him on~~ July 23 1946

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to Coronary Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

~~PHYSICIAN:~~ Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Cliffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed 7/23/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (306)

CERTIFICATE OF DEATH

06714 Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 812 Whatcoat St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: STEVENSON - THOMAS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Cora Stevenson, 812 Whatcoat St., Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years	Months	Days	If less than one day
36	unknown		___ hrs. ___ min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: July 21, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Anne Arundel County

18. Funeral director: Geo. G. Kelson

Address: 1303 Presstman St., Baltimore, Md.

19. 7-19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1946, to July 18, 1946 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days
Due to: Syphilis	unknown
Due to: ----	
Other conditions: General Paresis (?)	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op. ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 7/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

06715 P

CERTIFICATE OF DEATH

Reg. Diat. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A A

City or town: Freetown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Freetown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah F. Stewart

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	W

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2/14/1885

8. AGE:

Years	Months	Days	If less than one day
61	4	23	hrs. min.

9. Birthplace: Marley Neck

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Jacob Franklin

13. Birthplace: Md

MOTHER

14. Maiden name: Henrietta Curry

15. Birthplace: Md

18. Informant: Hiram Stewart

Address: Freetown A. A. Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-11-46 (month) (day) (year)

Cemetery or crematory: Halls Memorial

Location: A. A. Co., Md

18. Funeral director: Isaiah L. Brown & Son

Address: 108 W Montgomery St

19. 7-11 46 (Date rec'd by registrar) (19) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 19 46 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/8/46 19 to 7/8/46 19 and that I last saw h alive on 7/6/46 19

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Chronic Diffuse Nephritis	6 Months
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John F. Magruder M. D. or Other

Address: Glen Burnie Date signed: 7/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06716

Reg. Dist. No. —

1. PLACE OF DEATH:

County A A Co.

City or town Cedar Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A A Co.

City or town Cedar Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. Ritchie Highway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Utz Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Theresa

6.(c) If slive, give age D years

7. Birth date of deceased (mo., day, yr.) July 6, 1873

8. AGE: Years 73 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Supt

11. Industry or business Cedar Hill Cem.

FATHER 12. Name John Utz Sr.

FATHER 13. Birthplace Penna.

MOTHER 14. Maiden name Charlotte Brown

MOTHER 15. Birthplace Baltimore Md.

16. Informant Mr John E Utz

Address 3704 Magie St.

17. Burial Date thereof 7/18/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18. Funeral director John F Hennessy Inc

Address 715 Light St.

19. 7-18-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1946, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1945 19... to July 15 1946

and that I last saw h... alive on July 14 1946

Immediate cause of death	DURATION
Coronary Occlusion	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H Phillips M. D. or other

Address 1939 Edmondson Ave. Date signed 7-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06717

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Green Haven, P.O. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/3 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: P.O. Pasadena,

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 14 street - Green Haven.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Carol Catherine Halton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S.

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 23 - 1946.

8. AGE: Years	Months	Days	If less than one day
	1	16	..... hrs. ..... min.

9. Birthplace: Green Haven, Md

(Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER — 12. Name: James O. Halton.

13. Birthplace: Irvington, Va.

MOTHER — 14. Maiden name: Edith M. Shackles

15. Birthplace: Baltimore, Md.

16. Informant: The parents,

Address: Green Haven, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9 1946 (month) (day) (year)

Cemetery or crematory: Mt. Carmel Church yard

Location: A.A. Co. Md. (Mountain Road)

18. Funeral director: Thomas W. Singleton

Address: New Burnie, Md.

19. July 8 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1946, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Conflagration -	
Due to: Baby left between parents and mother - and was found dead - by parents when they woke up.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident. Date of 7/7/46

Where did injury occur? Green Haven (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Ignatius H. Pantelakis M.D.

acting Medical Examiner M. D. or other

Address: Glen Burnie, Md. Date signed 7/7/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

06718 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Joseph R. Wampler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Jane Lasking
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1872

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Francis Wampler
13. Birthplace: Md

MOTHER
14. Maiden name: Francis Bowers
15. Birthplace: Md

16. Informant: Anna D. Fields
Address: 202 Fifth Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13, 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Annapolis Blvd
18. Funeral director: John F. Clemm Inc.
Address: 715 Light Street

19. 7-12-46 (Date rec'd by registrar) Accepted (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1946, at 2 40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1946 to July 10 1946 and that I last saw h... alive on July 9 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 days
Due to Arterio Sclerosis	unknown
Due to Chronic myocarditis with extra systoles, non rheumatic.	unknown
Other conditions (Hypertensive Cardio vascular disease)	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Peterman M.D.
M. D. or other
Address: 1226 Hanover St Baltimore 30 Md. Date signed: July 11, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06719

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shoreham Beach Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Shoreham Beach, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Ramsey Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Evelyn Bell Waters

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Joseph L.
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): 7-18-1883

8. AGE: Years	Months	Days	If less than one day
63			...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business

FATHER
12. Name: Cornelius H. Helms
13. Birthplace: Virginia

MOTHER
14. Maiden name: Fannie B. Triplett
15. Birthplace: Virginia

16. Informant: Mr. J. L. Waters
Address: 1415 G. st. S.E.

17. Cedar Hill Cem. (Burial, cremation, or removal. Which?) Date thereof: 7-22-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location:

18. Funeral director: J. William Lee Son
Address: 300-4th st. N.E.

19. July 20 19 46 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1946 at 3:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1946 to July 19 1946 and that I last saw h.. alive on July 18 1946

Immediate cause of death	DURATION
generalized carcinomatosis-	1/2 yr.
Due to: Carcinoma of Rt breast	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: S. Borrough MD (M. D. or other)
Address: Annapolis Md Date signed: 7/19/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

Reg. Diat. No. 16720 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Elizabeth White

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	col	~~Widow~~ Married

6.(b) Name of husband or wife: George White,
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 1 1889

8. AGE: Years: 57 | Months: 5 | Days: 26 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Galesville (Town, county, and state)
10. Usual occupation: House work
11. Industry or business

FATHER
12. Name: Thos. Booze
13. Birthplace: Galesville

MOTHER
14. Maiden name: Martha Ann Booze
15. Birthplace: Galesville

16. Informant: Chester White
Address: Galesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 1946 (month) (day) (year)
Cemetery or crematory: Bethany Cem.
Location: Galesville Md

18. Funeral director: T. A. Hardesty & Son
Address: Galesville Md

19. 7/30 1946 W. H. Taylor
(Date rec'd by registror) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1946, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1946 to July 27 1946 and that I last saw h[illegible] alive on July 27, 1946.

Immediate cause of death	DURATION
Heart Failure	
Due to Chronic Myocarditis	2 years
Due to	
Other conditions Uremia - Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: X
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury, Injured at work?

23. SIGNATURE: R. L. Richardson M. D.
M. D. or other
Address: Riviera Beach, Md. Date signed: July 30, 1946

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

(X) 06721

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Marley Park - P.O. Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Marley Park, P.O. Glen Burnie, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: The Greenway.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Minnie Estelle Wood.

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: William C. Wood.

6.(c) If alive, give age: dead. years

7. Birth date of deceased (mo., day, yr.): August 22 1871

8. AGE: Years	Months	Days	If less than one day
74	11	0	..... hrs. ..... min.

9. Birthplace: Kent County, Maryland.
(Town, county, and state)

10. Usual occupation: housekeeping.

11. Industry or business

FATHER 12. Name: Robert Downey

FATHER 13. Birthplace: Maryland.

MOTHER 14. Maiden name: Mary Elizabeth Dowling.

MOTHER 15. Birthplace: Maryland.

16. Informant: Thomas Hodges (son)

Address: Marley Park, P.O. Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 24, 1946 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md

19. July 23 1946 (Date rec'd by registrar) W. R. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1946, at 12:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to July 22 1946, and that I last saw h alive on 7/22/46 1946

Immediate cause of death	DURATION
Acute Hemorrhage	4 days.
Due to: Hypertension	2 years.
Due to: Senility	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Faulenbach M. D. or other

Address: Glen Burnie Md Date signed 7/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15